

**CRITERIA FOR PRIOR AUTHORIZATION**

**Beta-Blocker/Angiotensin II Receptor Blockers Combinations Step Therapy**

**PROVIDER GROUP** Pharmacy

**MANUAL GUIDELINES** The following drug requires prior authorization:  
Nebivolol/valsartan (Byvalson®)

**CRITERIA FOR PRIOR AUTHORIZATION APPROVAL** (must meet all of the following):

- Patient must have a diagnosis of hypertension
- Patient must have a trial of concurrent use of nebivolol plus generic valsartan for at least 90 days

**LENGTH OF APPROVAL:** 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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PHARMACY PROGRAM MANAGER  
DIVISION OF HEALTH CARE FINANCE  
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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